Life with hope, LLC
Marriage and Family Therapy

CLIENT INFORMATION

First Name _____Middle Initial __Last Name _____ Preferred or Nick Name_____

(Check one) ☐ M or ☐ F Date of Birth: __ / __ / ____ Marital Status (check one): ☐ Married ☐ Single ☐ Other

Employment Status: ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Retired ☐Other: _____

Home Address: _____
Street City Zip

Telephone numbers: HOME _____ WORK _____ Work Extension ____ CELL _____

Cell phone carrier: ☐ AllTel ☐ AT&T ☐ Boost ☐ NexTel ☐ Sprint ☐ SunCom ☐ T-Mobile ☐ Verizon
☐ VoiceStream ☐ Virgin ☐ Other: _____

Email address: _____

How would you like appointment reminders sent to you? ☐ Email (Requires email address)
☐ Text message (Requires cell number and carrier)
☐ Phone call (Required Home phone number)
☐ None (No reminder will be sent)

Whom shall we thank for the referral? _____

IF CLIENT IS A MINOR, Names of parents or guardians who live with child:

Name _____ (check one) ☐ Father, ☐ Mother, ☐ Other _____

Name _____ (check one) ☐ Father, ☐ Mother, ☐ Other: _____

Name(s) of **parents** who do not live with child: _____

Address_____
Street City State Zip

Whom shall we call in an emergency? _____ Relationship to client _____

Telephone number(s): _____ _____

Name of **person** responsible for payment: _____ SSN _____ DOB _____

Address (if not listed above) _____City _____Zip _____

OK to keep charge card information in a secure file for future use? ☐ YES ☐ NO

If insurance will be used, fill in this section

Primary Insurance Company _____ID # _____Group # _____

Telephone number for Mental Health information _____ Authorization # _____

Insured person's name (Last, First, MI) _____

Insured person's Address _____
Street City State Zip

Insured person's Date of Birth (e.g. 1/1/13) _____

Relation of insured to client: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Life with hope, LLC
Marriage & Family Therapy

DISCLOSURES

Generally speaking, the information you provide will be confidential and cannot be disclosed without your consent. There are exceptions to the general rule of confidentiality. These exceptions are listed in the Florida Statutes (Title XXXII, Chapter 491, Section 491.0147). We will identify other exceptions to you as situations arise during therapy. You need to know that all child and elder abuse situations, and suicide and homicide plans need to be reported.

Our "Privacy Policies Statement" is available for download and printing on our web site. Additionally, paper copies are available in our Office waiting room. Your signature below indicates that you have had an opportunity to read and understand this document and that you agree to its stipulations. Our Staff will be glad to explain any parts that are unclear to you.

The Florida Department of Health Medial Quality Assurance Board of Clinical Social Workers, Mental Health Counselors, and Marriage and Family Therapists has the general responsibility of regulating the practice of licensed individuals who practice psychotherapy. As a participant in the psychotherapy process you need to be informed of the following:

1. Our practice emphasizes family systems and behavioral therapy principles. The focus of treatment will be in determining goals for successful completion of therapy and discussing strategies to help you achieve those goals. The duration of psychotherapy is typically 20-30 sessions.
2. You can seek a second opinion from another psychotherapist or terminate therapy at any time. There are numerous psychotherapy practice styles you can pursue if you do not want to engage in behavior therapy modality.
3. We may consult with other clinicians at Life with Hope, LLC to maximize the effectiveness of treatment.
4. Psychotherapy is not an exact science; therefore, no guarantees can be made regarding the process or outcome of the services.
5. Our mental health record-keeping system is predominantly paper documentation. The only personal electronic information stored is information needed to complete billing for services.
6. We are members of several provider networks and groups, and members of those groups cannot be held liable or responsible for your therapy process or outcome.
7. My emergency system involves a pre-recorded message on voice mail system with instructions advising callers to call 911. If a client feels the need is to talk only to a therapist, leave a message and a counselor will call back as soon as possible.
8. Florida law requires that when biological parents are divorced from each other, both must consent to treatment of a minor child before a child is presented for psychotherapy. It is the responsibility of the presenting parent to notify and obtain consent from the absent parent. Life with Hope, LLC and its associates and staff do <u>not</u> take responsibility for notifying parents and cannot be held liable for any failure to notify parents.
9. In a professional relationship such as ours, sexual intimacy between psychotherapist and a client is never appropriate. If sexual intimacy occurs it should be reported to the State Grievance Board. Furthermore, any personal relationship beyond the scope of psychotherapy is strictly forbidden for a minimum of three years after psychotherapy had ended.
10. I affirm that I have been given an opportunity to read the Life with Hope, LLC *Privacy Practices* statement.

☐ I Accept OR ☐ Do NOT Accept these disclosures.

_____ _____

Client or Legal Guardian's Name Date

Life with hope, LLC
Marriage & Family Therapy

INFORMED CONSENT

In compliance with national standards of ethics, Life with Hope, LLC is required to disclose all billing and financial matters regarding psychotherapy and neurofeedback services. As a client of Life with Hope, LLC, you understand:

1. Usual and customary rates for providing direct face-to-face psychotherapy services are $85.00 to $120.00 per 45-minute session.
2. All the income that supports Life with Hope, LLC, and its therapists and staff is entirely dependent upon clinical hours completed. Therefore, it is critically important that if you need to cancel your appointment, you please call and give 24-hours notification. This notification allows us to attempt to fill the time slot with clients needing a sooner appointment. Clients not giving 24-hours notice will be billed $50.00 for the missed appointment and this fee must be paid prior to the next appointment. More than two missed appointments or late cancellations will require a $50.00 deposit prior to any further sessions being scheduled. This policy may be waived in the case of serious illness or family emergency provided the client or client's representative calls as soon as possible and before the scheduled appointment. Examples of emergencies are: illness of the client or illness of a person for whom the client is caretaker.
3. Our office answering machine is secure and you may leave information with confidence. Late arrival by more than 15 minutes may be considered as a No-Show and therefore may result in your not being seen, and being charged accordingly. Please call our office to notify us if you are running late.
4. Your insurance company/managed care company reimburses services at a rate depending on the insurance plan. <u>You agree to pay for any charges that are not paid by your insurance company</u>, regardless of the reason for denial of payment.
5. Your fee or co-payment is due at the beginning of each session.
6. You will be billed for non-covered and non-routine services such as extended telephone consultation, crisis intervention, report writing, and/or extended care coordination with other providers at a rate of $2.50 per minute. You will be informed of events involving additional billing prior to the event.
7. Copies of a client's chart will be furnished to clients or other medical or mental health caregivers at the request of the client at no charge. Copies for court proceedings or other uses will be furnished at $2.00 per sheet.
8. **Our policy is not to provide legal testimony**. If compelled to provide testimony by court order, the client will be billed at the rate of $210.00 per hour including time driving to and from the place of testimony and preparation for the testimony. A retainer of $1,680.00 will be required.
9. Balances owed to Life with Hope, LLC that are over 90 days past due are turned over to a collection agency for collection.

☐ I understand and Consent OR ☐ I Do NOT Consent.

_____ _____

Client or Legal Guardian's Name Date

Life with hope, LLC
Marriage & Family Therapy

UNDERSTANDINGS AND AUTHORIZATIONS

Please read the following statements carefully. If you have questions, ask a member of our staff.

1. If I direct Life with Hope, LLC [LWH] to file insurance claims for the client, I authorize LWH to furnish such personal and clinical information as needed to process claims and receive payments. I understand that the confidentiality of such information given to insurance companies cannot be guaranteed. Therefore, I agree to hold harmless Life with Hope, LLC and its staff and associates of any damages resulting from a breach in confidentiality that may occur as a result.

2. I understand that I have a right to access and copy my own confidential client file in accordance with the requirements of the federal privacy protection regulations founded under 45 CFR 164.524. The therapists treating the client and the office staff may have access to the files. No other persons may have access to the files or information without my written consent. A form is available for the purpose of giving consent – "Authorization to Use and/or Disclose Protected Health Information."

3. I authorize LWH to mail correspondence or financial statements to the client's Home, **Or**, this address: _____

4. (Please check one):
   ☐ I authorize LWH to receive payments for benefits from my managed care/insurance company:

   ☐ I prefer to have insurance payments come directly to me or to the designated insurance subscriber. *(Choosing this option requires full payment of fee to LWH by subscriber or responsible party at time of service. If no check is made, your choice will be considered as a choice to have LWH receive payments for you.)*

5. I understand that LWH will make every effort to reach me with a reminder of my scheduled appointments; however, I do not hold LWH responsible for any failure to reach me.

   ☐ I understand and agree to these authorizations OR ☐ I Do NOT agree to these authorizations..

_____ _____
Name of Client or Legal Guardian Date